104TH CONGRESS
1ST SESSION

S. 1062

To amend the Employee Retirement Income Security Act of 1974 to increase the purchasing power of individuals and employers, to protect employees whose health benefits are provided through multiple employer welfare arrangements, to provide increased security of health care benefits, and for other purposes.

IN THE SENATE OF THE UNITED STATES

JULY 21 (legislative day, JULY 10), 1995

Mr. JEFFORDS (for himself and Mr. NUNN) introduced the following bill; which was read twice and referred to the Committee on Labor and Human Resources

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A BILL

To amend the Employee Retirement Income Security Act of 1974 to increase the purchasing power of individuals and employers, to protect employees whose health benefits are provided through multiple employer welfare arrangements, to provide increased security of health care benefits, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE; AMENDMENT OF ERISA.

(a) SHORT TITLE.—This Act may be cited as the ''Employer Group Purchasing Reform Act of 1995''.

(b) AMENDMENT OF ERISA.—Except as otherwise expressly provided, whenever in this Act an amendment is expressed in terms of an amendment to a section or other provision, such reference shall be treated as a reference to a section or other provision of the Employee Retirement Income Security Act of 1974.

SEC. 2. DEFINITIONS AND SPECIAL RULES.

Section 3(1) (29 U.S.C. 1002(1)) is amended—

(1) by striking ''(1) The terms'' and inserting ''(1)(A) The terms''; and

(2) by adding at the end thereof the following new subparagraphs:

''(B)(i) The term 'employee benefit group health plan' means any plan or arrangement (whether fully insured or self-funded) that provides, or pays for health benefits (such as physician and hospital benefits). Such term does not include any of the following, or a combination thereof:

''(I) Coverage only for accidental death, dismemberment, dental, or vision.

''(II) Coverage providing wages or payments in lieu of wages for any period during which the employee is absent from work on account of sickness or injury.

''(III) A medicare supplemental policy (as defined in section 1882(g)(1) of the Social Security Act).

''(IV) Coverage issued as a supplement to liability insurance.

''(V) Workers' compensation or similar insurance.

''(VI) Automobile medical payment insurance.

''(VII) A long-term care insurance policy, including a nursing home fixed indemnity policy.

''(VIII) Any plan or arrangement not described in any preceding subparagraph that provides for benefit payments, on a periodic basis, for a specified disease or illness or period of hospitalization without regard to the costs incurred or services rendered during the period to which the payments relate.

''(IX) Coverage provided through a State risk pool, uncompensated care pool, or similar subsidized program.

''(X) Such other plan or arrangement as the Secretary determines is not an employee benefit group health plan.

''(ii) The term 'health insurer' means an entity which is licensed and authorized under State law to offer health service insurance or health indemnity insurance contracts, including the following:

''(I) a licensed insurance company;

''(II) a licensed prepaid network plan (such as a preferred provider organization or health maintenance organization); or

''(III) any other entity (other than an entity described in paragraph (12)) (providing a plan of health insurance or health benefits) with respect to which State insurance laws are not preempted under section 514 of this Act.

''(iii) The term 'prepaid network plan' means an employee benefit group health plan that arranges for the financing and delivery of health care services to persons covered under such health plan, in whole or in part, through arrangements with providers to furnish such health care services.

''(C) The term 'health plan purchasing coalition' has the meaning given such term in section 802(a).

''(D) The term 'fully insured health plan' means an arrangement under which all benefits (with the exception of co-payments and deductibles)

are provided in an amount that is guaranteed under a policy of insurance issued by a health insurer.

''(E) The term 'self-funded health plan' means an employee benefit group health plan under which the employer or plan sponsor retains substantial risk for providing benefits under the plan as provided by regulations promulgated by the Secretary of Labor.''.

TITLE I—EMPLOYEE GROUP HEALTH PLAN SECURITY

SEC. 101. EMPLOYEE BENEFIT GROUP HEALTH PLAN NONDISCRIMINATION REQUIREMENTS.

Section 510 (29 U.S.C. 1140) is amended—

(1) by striking ''510. It shall'' and inserting ''510. (a) IN GENERAL.—It shall''; and

(2) by adding at the end thereof the following new subsections:

''(b) EMPLOYEE BENEFIT GROUP HEALTH PLAN NONDISCRIMINATION REQUIREMENTS.—

''(1) IN GENERAL.—An employee benefit group health plan (whether fully insured or self-funded) in force on or after the date of enactment of this subsection, may not deny any coverage or establish eligibility, continuation, enrollment, or contribution requirements for participants or beneficiaries based on

health status, medical condition, claims experience, receipt of health care, medical history, anticipated need for health care, evidence of insurability, or disability of a participant or beneficiary.

''(2) HEALTH PROMOTION EXCEPTION.—Nothing in this subsection shall prevent an employee benefit group health plan from establishing discounts for participation in programs of health promotion or disease prevention.

''(3) LIMITATION ON PREEXISTING CONDITION EXCLUSIONS AND LIFETIME LIMITS.—

''(A) IN GENERAL.—An employee benefit group health plan (fully insured or self-funded) may impose a limitation or exclusion of benefits relating to treatment of a condition based on the fact that the condition preexisted the effective date of the plan with respect to a participant or beneficiary only if—

''(i) the condition was diagnosed or treated during the 6-month period prior to the date of enrollment in the health plan;

''(ii) the limitation or exclusion extends for a period of not more than 12 months after the date of enrollment in the health plan;

''(iii) the limitation or exclusion does not apply to an individual who, within 30 days of the date of birth of the individual, was covered under the plan; and

''(iv) the limitation or exclusion does not apply to a pregnancy existing on the effective date of coverage.

''(c) CREDITING OF QUALIFYING PREVIOUS COVERAGE.—

''(1) IN GENERAL.—An employee benefit group health plan (whether fully insured or self-funded) shall provide that if a participant or beneficiary is in a period of previous qualifying coverage as of the date of enrollment under such plan, any period of exclusion or limitation of coverage with respect to a preexisting condition shall be reduced by 1 month for each month in which the participant or beneficiary was in the period of previous qualifying coverage.

''(2) DISCHARGE OF DUTY.—The duty of an employer or plan sponsor to verify previous qualifying coverage with respect to a participant or beneficiary is effectively discharged when such plan sponsor provides documentation to a participant or beneficiary at the time such participant or beneficiary be-

comes ineligible for coverage under the group health plan verifying—

''(A) the dates that the participant or beneficiary was covered under such previous qualifying coverage;

''(B) the benefits and cost-sharing arrangement available to the participant or beneficiary under such previous qualifying coverage; and

''(C) the preexisting condition limitations or exclusions, if any, that applied to the plan under such previous qualifying coverage.

''(3) DEFINITION.—The term 'previous qualifying coverage' means the period beginning on the date a participant or beneficiary is enrolled under a health plan and ends on the date the participant or beneficiary is not so enrolled for a continuous period of more than 30 days (without regard to any waiting period).

''(d) LIFETIME LIMITS.—An employee benefit group health plan (whether fully insured or self-funded) may not impose a catastrophic or lifetime limit with respect to coverage under the plan.''.

SEC. 102. DISCLOSURE REQUIREMENTS.

(a) DISCLOSURE OF INFORMATION BY INSURERS.—Part 1 of subtitle B of title I (29 U.S.C. 1021 et seq.) is amended by adding at the end thereof the following new section:

"SEC. 112. DISCLOSURE OF INFORMATION BY INSURERS.

''(a) IN GENERAL.—In connection with the offering for sale of any employee benefit group health plan to an employer or plan sponsor, an insurer shall make a reasonable disclosure, as part of its solicitation and sales materials, of—

''(1) the provisions of the group health plan concerning the insurer's right to change premium rates and the factors that affect changes in premium rates;

''(2) the provisions of such plan relating to renewability of policies and contracts;

''(3) the provisions of such plan relating to any preexisting condition provision; and

''(4) descriptive information about the benefits available under all benefit plans for which the employer is qualified.

Information shall be provided under this subsection in a manner determined to be understandable by the typical plan participant and beneficiary, and shall be accurate and

comprehensive to reasonably inform employers and participants of their rights and obligations under the plan.

''(b) EXCEPTION.—With respect to the requirements of subsection (a), any information that is determined by the insurer to be proprietary and trade secret information, or competitively sensitive information, shall not be subject to the disclosure requirements of such subsection except as agreed to by the insurer.''.

(b) DISCLOSURE TO PARTICIPANTS AND BENEFICIARIES IN SELF-FUNDED EMPLOYEE BENEFIT GROUP HEALTH PLANS.—Part 1 of subtitle B of title I (29 U.S.C. 1021 et seq.) (as amended by subsection (a)) is further amended by adding at the end thereof the following new section:

"SEC. 113. DISCLOSURE TO PARTICIPANTS AND BENEFICIARIES IN SELF-FUNDED EMPLOYEE BENEFIT GROUP HEALTH PLANS.

''(a) REQUIREMENT.—

''(1) IN GENERAL.—Each self-funded employee benefit group health plan shall issue to each participant and beneficiary, in language determined to be easily understandable by the typical participant or beneficiary, a statement indicating—

''(A)(i) that the plan is enforced under this Act and is not a licensed health plan under the laws of any State;

''(ii) that the plan is not required to provide any State-mandated benefits; and

''(iii) that the plan is not required to participate in State guarantee funds; and

''(B) that, if the plan does not pay all benefits for which participants or beneficiaries are eligible under the arrangement, responsibility for payment for medical care may to some extent remain with the participant or beneficiary.

''(2) TIME FOR DISCLOSURE.—The information described in paragraph (1) shall be provided to each participant and beneficiary within 30 days after the close of each fiscal year of the arrangement and within such reasonable time before commencing coverage under the arrangement as the Secretary shall prescribe by regulation.

''(b) NOTICE OF MATERIAL CHANGES.—

''(1) IN GENERAL.—Each self-funded health plan shall issue to each participant and beneficiary, in language determined to be easily understandable to the typical participant or beneficiary, a notice de-

scribing any material change in the terms of the plan.

''(2) TIME FOR DISCLOSURE.—The notice referred to in paragraph (1) shall be issued to each participant and beneficiary within 30 days after the earlier of the date of the adoption of the material change involved or the effective date thereof.''.

SEC. 103. PLAN TERMINATION REQUIREMENTS.

Part 6 of subtitle B of title I (29 U.S.C. 1161 et seq.) is amended by adding at the end thereof the following new section:

"SEC. 610. GROUP HEALTH PLAN TERMINATION NOTIFICATION REQUIREMENTS.

''(a) IN GENERAL.—Not later than 90 days prior to the termination of any employee benefit group health plan (whether the plan is fully insured or self-funded), the plan sponsor shall notify each participant and beneficiary of such termination. During such 90-day period, an employer may not—

''(1) modify benefits as described in the most recent plan document; or

''(2) modify employer contribution rates.

''(b) PROOF OF PLAN INVOLUNTARY TERMINATION POLICY.—

''(1) IN GENERAL.—Except as provided in paragraph (4), the plan sponsor shall submit to the Secretary, for each self-funded employee benefit group health plan, evidence of the existence of a plan involuntary termination policy. Such termination policy—

''(A) shall be submitted on an annual basis;

''(B) shall be issued either by—

''(i) a State-licensed insurer; or

''(ii) a United States domiciled State-licensed captive insurer, as determined in regulations promulgated by the Secretary;

''(C) shall provide each participant or beneficiary 90 days of coverage beyond the date of plan termination; and

''(D) shall provide for all outstanding benefit payments covered under the plan.

''(2) ISSUANCE.—The requirements of paragraph (1) may be met through surety bonds, letters of credit, or other appropriate security to the extent provided in regulations issued by the Secretary.

''(3) COVERAGE.—For purposes of this paragraph (1)(C), the term 'coverage' means coverage for the same benefits as described in the latest summary plan document.

''(4) EXCEPTION.—Notwithstanding the requirements of this section, a self-funded employee benefit group health plan that is subject to the requirements of this section, shall not be required to meet the requirements of paragraphs (1) and (2) if—

''(A) in the case of an employee benefit group health plan or plans maintained by a single employer, the employer has received at least a AAA bond credit rating or an equivalent credit rating from a credit rating agency certified for such purpose by the Secretary; and

''(B) in the case of an employee benefit group health plan that is multiemployer plan that is collectively bargained and meets the requirements of section 302 of the Labor Management Relations Act of 1947 (29 U.S.C. 186), the trustees of the plan have entered into withdrawal liability agreements with the contributing employers to the plan which are approved by the Secretary.

The requirements of subparagraphs (A) and (B) are met with respect to an employee benefit group health plan if the plan submits on an annual basis

to the Secretary a statement of compliance with either such paragraph.''.

TITLE II—MULTIPLE EMPLOYER WELFARE ARRANGEMENT REFORM

SEC. 201. DEFINITIONS.

(a) CLARIFICATION OF STATUS OF PLANS MAINTAINED BY PARTICIPATING EMPLOYERS UNDER MULTIPLE EMPLOYER WELFARE ARRANGEMENTS.—Section 3(1)(A) (29 U.S.C. 1002(1)) (as amended by section 2) is further amended by adding at the end the following new sentence: ''Irrespective of whether a multiple employer welfare arrangement is (or is treated as) a plan under this title, each participating employer under such arrangement shall be treated as maintaining by means of such arrangement an employee welfare benefit plan under which the employees of such employer who are covered under such arrangement are the participants.''.

(b) MODIFICATIONS TO DEFINITION OF MULTIPLE EMPLOYER WELFARE ARRANGEMENT.—Paragraph (40) of section 3 (29 U.S.C. 1002(40)) is amended by adding at the end the following new subparagraph:

''(C)(i) The term 'multiple employer welfare arrangement' includes an employee welfare benefit plan which is established or maintained for the pur-

pose of offering or providing any benefit described in paragraph (1) to individuals (or their beneficiaries) who perform services pursuant to an employee leasing arrangement if—

''(I) under such employee leasing arrangement the lessor does not retain, both legally and in fact, the right of direction and control within the scope of employment over the individuals whose services are supplied under the arrangement,

''(II) under the employee leasing arrangement the lessor's responsibility for payment of wages, payroll related taxes, and employee benefits of such individuals is, either legally or in fact, dependent upon payment by the lessee to the lessor for its services,

''(III) employee leasing services provided under the employee leasing arrangement are solicited, advertised, or marketed through or by licensed insurance agents or brokers, or

''(IV) any owner or director of, any partner in, or any relative of, the lessee is an employee of the lessor or is eligible to participate in the employee welfare benefit plan or other arrangement.

''(ii) For purposes of this subparagraph, the term 'employee leasing arrangement' means any labor leasing arrangement, staff leasing arrangement, extended employee staffing or supply arrangement, or other arrangement under which one business or other entity (referred to in this subparagraph as the 'lessee') receives, under a lease or other arrangement entered into with any other business or other entity (referred to in this subparagraph as the 'lessor'), services of individuals to be performed under such lease or other arrangement.''.

(c) REGISTRATION REQUIREMENTS FOR MEWA'S.—Paragraph (40) of section 3 (29 U.S.C. 1002(40)) as amended by subsection (c), is further amended by adding at the end the following new subparagraph:

''(D) The Secretary shall by regulation provide for the registration of multiple employer welfare arrangement with the Secretary on an annual basis.''.

(d) CLARIFICATION OF TREATMENT OF SINGLE EMPLOYER ARRANGEMENTS.—Section 3(40)(B) (29 U.S.C. 1002(40)(B)) is amended—

(1) in clause (i)—

(A) by inserting ''for any plan year of any such plan, or any fiscal year of any such other arrangement,'' after ''single employer''; and

(B) by inserting ''during such year or at any time during the preceding 1-year period'' after ''common control'';

(2) in clause (iii)—

(A) by striking ''common control shall not be based on an interest of less than 25 percent'' and inserting ''an interest of greater than 25 percent may not be required as the minimum interest necessary for common control'';

(B) by striking ''similar to'' and inserting ''consistent and coextensive with''; and

(C) by striking ''and'' at the end;

(3) by redesignating clause (iv) as clause (v); and

(4) by inserting after clause (iii) the following new clause:

''(iv) in determining, after the application of clause (i), whether benefits are provided to employees of two or more employers, the arrangement shall be treated as having only 1 participating employer if, after the application of clause (i), the number of individuals who are employees and former employees of any one participating employer and who are covered under the arrangement is greater than 85 percent of the aggregate number of all individuals who

are employees or former employees of participating employers and who are covered under the arrangement.''.

SEC. 202. MODIFICATION OF PREEMPTION RULES FOR MULTIPLE EMPLOYER WELFARE ARRANGEMENTS.

(a) STATE LAWS NOT PREEMPTED.—Subparagraph (A) of section 514(b)(6) (29 U.S.C. 1144(b)(6)(A)) is amended to read as follows:

''(A) In the case of a multiple employer welfare arrangement which is an employee benefit group health plan (whether fully insured or self-funded) in addition to this title, any law of any State which regulates insurance may apply.''.

(b) OTHER PREEMPTION RULES.—Section 514(b)(6) (29 U.S.C. 1144(b)(6)) is amended by striking subparagraphs (B) and (C) and inserting in lieu thereof the following new subparagraph:

''(B) Nothing in this title shall be construed as prohibiting a State from—

''(i) requiring any person to provide information or documentation which the insurance commissioner (or similar official) of the State deems necessary to enable the State to determine whether an entity is a multiple employer welfare arrangement, or

''(ii) applying generally applicable licensing requirements with respect to the services of contract administrators or other licensed professionals whose services are provided to a multiple employer welfare arrangement.''.

SEC. 203. APPLICATION OF CRIMINAL PENALTIES.

(a) IN GENERAL.—Section 501 (29 U.S.C. 1131) is amended by adding at the end the following new subsection:

''(b) Any person who, in connection with a multiple employer welfare arrangement established or maintained for the purpose of offering or providing any employee benefit group health plan benefit to employees or their beneficiaries, willfully and knowingly makes a false representation to any employer, any employee, any employee's beneficiary, any State, or the Secretary as to the status of the arrangement under this Act, or as to the relationship of the arrangement to any employer or to any employee organization (including any national or international employee organization or federation of such organizations), shall, upon conviction, be fined not more than $5,000 ($100,000 in the case of persons other than individuals), or be imprisoned not more than 1 year, or both.''.

(b) CONFORMING AMENDMENT.—Section 501 (29 U.S.C. 1131) is amended by inserting ''(a)'' after ''SEC. 501.''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to any action taken on or after the date of the enactment of this Act.

TITLE III—HEALTH PLAN PURCHASING COALITIONS

SEC. 301. HEALTH PLAN PURCHASING COALITIONS.

(a) IN GENERAL.—Subtitle B of title I (42 U.S.C. 1021 et seq.) is amended by adding at the end thereof the following new part:

"Part 7—Health Plan Purchasing Coalitions

"SEC. 801. APPLICABILITY.

''The requirements of this part shall apply to all registered health plan purchasing coalitions.

"SEC. 802. HEALTH PLAN PURCHASING COALITIONS.

''(a) DEFINITION.—As used in this part, the term 'health plan purchasing coalition' means a group of individuals or employers that, on a voluntary basis and in accordance with this section, form an entity for the purpose of providing insured health plans for its membership. An insurer, agent, broker or any other individual or entity engaged in the sale of insurance may not form or underwrite a coalition.

''(b) CERTIFICATION.—

''(1) IN GENERAL.—A State shall certify health plan purchasing coalitions that meet the requirements of this section. Each coalition shall be chartered under State law and registered with the Secretary of Labor.

''(2) STATE REFUSAL TO CERTIFY.—If a State fails to implement a program for certifying health plan purchasing coalitions in accordance with the standards under this Act, the Secretary shall certify and oversee the operations of such coalitions in such State.

''(3) INTERSTATE COALITIONS.—

''(A) IN GENERAL.—For purposes of this section, a health plan purchasing coalition operating in more than one State shall be certified by the State in which the coalition is domiciled.

''(B) CHARTER.—An interstate health plan purchasing coalition shall be chartered by each State in which such coalition conducts business (such as offering membership to individuals or entities in a State or offering enrollment in health plans operating in a State). States may enter into cooperative arrangements for the

purpose of certifying and overseeing the operation of such coalitions.

''(C) DOMICILE.—For purposes of subparagraph (A), a health plan purchasing coalition shall be considered to be domiciled in the State in which the most participants and beneficiaries of the coalition are located.

''(4) STATE LOCATION OF PARTICIPANTS AND BENEFICIARIES.—

''(A) IN GENERAL.—A health plan purchasing coalition shall be treated as covering participants and beneficiaries located in a State only if the minimum required number of members who are covered under the coalition as participants and beneficiaries are located in such State, except that if the minimum required number of such individuals are not located in any State, such arrangement shall be treated as covering participants and beneficiaries in any State in which any participant or beneficiary is located.

''(B) MINIMUM REQUIRED NUMBER.—For purposes of subparagraph (A), the minimum required number is the greater of—

''(i) 5 percent of the total number of individuals described in subparagraph (A), or

''(ii) 100.

''(C) LOCATION OF INDIVIDUALS IN STATE.—For purposes of subparagraph (A), a participant or beneficiary shall be treated as located in a State if such participant or beneficiary is employed in such State or the address of such participant or beneficiary last known by the coalition is located in such State.

''(c) BOARD OF DIRECTORS.—

''(1) IN GENERAL.—Each health plan purchasing coalition shall be governed by a Board of Directors that shall be responsible for ensuring the performance of the duties of the coalition under this section. The Board shall be composed of a broad cross-section of representatives of employers, employees, and individuals participating in the coalition. An insurer, agent, broker or any other individual or entity engaged in the sale of insurance may not hold or control any right to vote with respect to a coalition.

''(2) LIMITATION ON COMPENSATION.—A health plan purchasing coalition may not provide

compensation to members of the Board of Directors. The coalition may provide reimbursements to such members for the reasonable and necessary expenses incurred by the members in the performance of their duties as members of the Board.

''(3) CONFLICT OF INTEREST.—No member of the Board of Directors (or family members of such members) nor any management personnel of the coalition may be employed by, be a consultant for, be a member of the board of directors of, be affiliated with an agent of, or otherwise be a representative of any health plan or other insurer, health care provider, or agent or broker. Nothing in the preceding sentence shall limit a member of the Board from purchasing coverage from a health plan offered through the coalition.

''(d) MEMBERSHIP AND MARKETING AREA.—

''(1) MEMBERSHIP.—

''(A) IN GENERAL.—A health plan purchasing coalition may establish limits on the size of employers who may become a member of the coalition, and may determine whether to permit individuals to become members. Upon the establishment of such membership requirements, the coalition shall, except as provided in

subparagraph (B), accept all employers (or individuals) residing within the area served by the coalition who meet such requirements as members on a first come, first-served basis.

''(B) CAPACITY LIMITS.—A health plan purchasing coalition may cease accepting employers or individuals as members of the coalition if—

''(i) the coalition ceases to permit any new employers or individuals to become members; and

''(ii) the coalition can demonstrate to the State (or the Secretary in the case of coalitions certified by the Secretary) that the financial or other capacity of coalition to serve current members will be impaired if the coalition is required to accept other members.

''(2) MARKETING AREA.—A State may establish rules regarding the geographic area that must be served by a health plan purchasing coalition. With respect to a State that has not established such rules, a health plan purchasing coalition operating in the State shall define the boundaries of the area to be served by the coalition, except that such bound-

aries may not be established on the basis of health status or insurability.

''(e) DUTIES AND RESPONSIBILITIES.—

''(1) IN GENERAL.—A health plan purchasing coalition shall—

''(A) enter into agreements with at least three, unaffiliated insured health plans, except that the requirement of subparagraph shall not apply in regions (such as remote or frontier areas) in which compliance with such requirement is not possible;

''(B) enter into agreements with employers and individuals who become members of the coalition;

''(C) participate in any program of risk-adjustment or reinsurance, or any similar program, that is established by the State;

''(D) prepare and disseminate comparative health plan materials (including information about cost, quality, benefits, and other information concerning health plans offered through the coalition);

''(E) actively market to all eligible employers and individuals residing within the service area; and

''(F) act as an ombudsman for health plan enrollees.

''(2) PERMISSIBLE ACTIVITIES.—A health plan purchasing coalition may perform such other functions as determined by the Board of Directors or the State (or the Secretary in the case of a coalition certified by the Secretary) to further the purposes of this part, including, but not limited to—

''(A) the collection and distribution of premiums and the performance of other administrative functions;

''(B) the collection and analysis of surveys of health plan enrollee satisfaction;

''(C) the charging of a membership fee to enrollees (such fees may not be based on health status) and the charging of participation fees to health plans;

''(D) cooperating with employers that self-fund for the purpose of negotiating with providers and health plans; and

''(E) otherwise contracting and negotiating with health plans and health care providers.

''(f) LIMITATIONS ON COALITION ACTIVITIES.—A health plan purchasing coalition shall not—

''(1) perform any activity relating to the licensing of health plans;

''(2) assume financial risk in relating to any health plan;

''(3) perform any other activities that conflict or are inconsistent with the performance of its duties under this part;

''(4) establish eligibility, continuation, enrollment, or contribution requirements for individuals based on health status, medical condition, claims experience, receipt of health care, medical history, evidence of insurability, or disability of the individual; and

''(5) operate on a for-profit or other basis where the legal structure of the coalition (as determined under guidelines developed by the Secretary) permits profits to be made and not returned to the members of the coalition.

''(g) RULES OF CONSTRUCTION.—Nothing in this section shall be construed to—

''(1) require that a State organize, operate, or otherwise create health care purchasing coalitions;

''(2) otherwise require the establishment of health care purchasing coalitions;

''(3) require individuals or employers to purchase health plans through a health care purchasing coalition;

''(4) require that a health plan purchasing coalition be the only type of health insurance purchasing arrangement permitted to operate in a State; or

''(5) establish a purchasing coalition as an employee welfare benefit plan.

''(h) HEALTH PLAN PURCHASING COALITION RELATIONSHIP TO PLAN SPONSORS.—

''(1) IN GENERAL.—With respect to a health plan purchasing coalition, each employer or plan sponsor member shall be treated as maintaining an employee welfare benefit plan on behalf of the plan participants and beneficiaries under the plan involved.

''(2) COALITION AS PLAN ADMINISTRATOR.—A health plan purchasing coalition may act as the plan administrator for any employer member of the coalition. In acting as such a plan administrator the coalition may—

''(A) collect and distribute premiums;

''(B) manage COBRA continuation coverage requirements;

''(C) provide summary plan description material to participants and beneficiaries; and

''(D) carry out any other administrative activities determined appropriate by the coalition.''.

(b) LIMITED PREEMPTION.—Section 514 (29 U.S.C. 1144) is amended by adding at the end thereof the following new subsection:

''(e)(1) Notwithstanding any other provision of this section, with respect to a health plan purchasing coalition that meets the requirements of part 7, the following State laws shall be preempted:

''(A) State fictitious group laws.

''(B) State rating requirement laws, except to the extent necessary to comply with the requirements of paragraph (2).

''(C) State mandated benefit laws, except to the extent necessary to comply with the requirements of paragraph (3).

''(D) Other State laws that directly conflict with the requirements in such part 7.

''(2) With respect to a State rating requirement law, a health plan purchasing coalition—

''(A) may not permit premium rates for health plans to vary among employers or individuals that

are members of a health plan purchasing coalition in excess of the amount of such variations that would be permitted under such State rating laws among employers that are not members of the coalition; and

''(B) with respect to premium rates negotiated by the coalition, may permit such rates to be less than rates that would otherwise be permitted under State law if such rating differential is not based on differences in health status or demographic factors.

''(3) With respect to a State mandated benefit law, a health plan purchasing coalition—

''(A) may apply any small group reform plan design of the State to health plans offered by the coalition; or

''(B) if the State has no specific small group plan design, may design a plan that shall apply to all health plans offered by the coalition.''.

SEC. 302. COOPERATION BETWEEN FEDERAL AND STATE AUTHORITIES.

Section 506 (29 U.S.C. 1136) is amended by adding at the end the following new subsection:

''(c) RESPONSIBILITY WITH RESPECT TO MULTIPLE EMPLOYER WELFARE ARRANGEMENTS AND HEALTH PLAN PURCHASING COALITIONS.—

''(1) STATE ENFORCEMENT.—

''(A) AGREEMENTS WITH STATES.—A State may enter into an agreement with the Secretary for delegation to the State of some or all of the Secretary's authority under sections 502 and 504 to enforce the provisions of this title applicable to multiple employer welfare arrangements and health plan purchasing coalitions.

''(B) DELEGATIONS.—Any department, agency, or instrumentality of a State to which authority is delegated pursuant to an agreement entered into under this paragraph may, if authorized under State law, exercise the powers of the Secretary under this title which relate to such authority.

''(C) CONCURRENT AUTHORITY OF THE SECRETARY.—If the Secretary delegates authority to a State in an agreement entered into under subparagraph (A), the Secretary may continue to exercise such authority concurrently with the State.

''(2) ASSISTANCE TO STATES.—The Secretary may—

''(A) provide enforcement assistance to the States with respect to multiple employer welfare

arrangements, including coordinating Federal and State efforts through the establishment of cooperative agreements with appropriate State agencies under which the Pension and Welfare Benefits Administration keeps the States informed of the status of its cases and makes available to the States information obtained by it,

''(B) provide continuing technical assistance to the States with respect to issues involving multiple employer welfare arrangements and this Act,

''(C) assist the States in obtaining from the Office of Regulations and Interpretations timely and complete responses to requests for advisory opinions on issues described in subparagraph (B), and

''(D) distribute copies of all advisory opinions described in subparagraph (C) to the State insurance commissioner of each State.''.

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